Episode 2 Transcript

Topic: Bad Apple Doctors: The role of criminal law in non-fatal surgical harm.

Hosted by: Professor Anne-Maree Farrell

Guest: Dr Alex Mullock

This transcript has been edited for clarity

00:01
Welcome to 'Mason Institute Investigates', a podcast series produced by the Mason Institute, funded by the Edinburgh Law School. In each episode we investigate current national and global issues involving ethics, law and policy in health, medicine, and the life sciences.

00:20
Welcome to our series on Current Issues in Health, Law, and Bioethics, sponsored by Edinburgh Law School's Mason Institute and the Centre for Social Ethics and Policy at the University of Manchester.

00:33 Professor Farrell:
I'm Anne-Maree Farrell, Professor of Medical Jurisprudence at Edinburgh Law School. Today I'm talking with a colleague who is Co-director of the Centre for Social Ethics and Policy, at the University of Manchester: Dr Alexandra or Alex Mullock. And we're talking about her research in the area of the criminal law and its relationship with medicine, and specifically in managing harm caused by doctors. So, Alex, perhaps you can introduce yourself, but also tell us a bit about the research that you've been doing generally in the area.

01:10 Dr Mullock:
Yeah, sure. Thank you so much. So, I'm Alex Mullock, I'm a senior lecturer in Medical Law at the University of Manchester within the Centre for Social Ethics and Policy, which I co-direct at the moment with my colleague, Dr Sarah Devaney. And so today I'm going to be talking about some work I've been doing on bad apple surgeons and this was sparked by my interest in two cases in 2017 involving surgeons who were convicted for offences against the person, and as far as I can work out, this is the first time that surgeons had been prosecuted and convicted and for non-fatal offences using the criminal law in England and Wales. So I was just really interested in terms of how the usual exception under the criminal law for consensual

reasonable surgery, how that was kind of conceptualised within the exercise of determining how and whether these two surgeons were criminally liable. So do you want me to tell you a little bit about the two cases?

02:30 Professor Farrell:
Well, yes you can, but first of all, I'd be very interested in your views on the broader issue of how we should understand the role of the criminal law in health and medicine, really whether it should be intervening at all? You spoke about the exceptions in the area. But there's been a lot of debate in the literature about whether there should be a degree of intervention and what intervention by the criminal law in health and medicine. And I know you've been researching the area, so would you mind addressing that for people who are perhaps unfamiliar with it?

03:07 Dr Mullock:
Yeah, of course. I mean, I think there's been a lot of attention on gross negligence manslaughter in the medical context and of course that's really, previously anyway, the only way that we saw doctors or surgeons who make catastrophic and fatal errors being held accountable within the criminal law, I mean, there are obviously other ways that the criminal law can engage in healthcare. There's been quite a few doctors who've been prosecuted for sexual offences, but I think the difference between doing that kind of offence and gross negligence manslaughter and the non-fatal offences, but as they might apply to surgical harm, is that within surgery and within the gross negligence manslaughter type cases, these are doctors or surgeons who are doing their job, on the face of it superficially in the way that they should be doing it, in sharp contrast with a doctor who is found to be guilty of sexually assaulting a patient where clearly they are not doing their job in in any sense of the word of in terms of how they ought to be doing it. And so it's particularly difficult I think, with both gross negligence manslaughter and non-fatal harm perpetrated in healthcare generally, but particularly in surgery perhaps, to look behind the superficially professional medical interaction to see whether a criminal offence has been committed.

04:45 Professor Farrell:
And certainly, under the common law jurisdiction it is that focus, as you say, on fatal error in healthcare settings. And certainly, if you then look to the bioethics literature, but also the law literature as well about this is troubling from the point of view of moral luck: that you can behave in terms of your conduct, in a grossly negligent manner, but if the patient doesn't pass away due to that grossly negligent conduct, you're not facing a gross negligence manslaughter

charge. And yet the harm that was caused was quite severe, and the conduct was deeply problematic as well. So that's something you're grappling with in your current research, is that the important fatal harm that's being caused and we're clear, at least in the English jurisdiction, about where the criminal law intervenes in that regard. But it's teasing out where that should lie. All that intervention should lie in non-fatal harm being caused in health care settings. Would that be right?

05:44 Dr Mullock:
Yeah, absolutely. As you said, there's been a lot of criticism about gross negligence manslaughter and our colleague Margaret Brazier and others have picked up on this sense of moral law and using the JC Smith's example of weed killer in a lemonade bottle: if a father stores this dangerous chemical in in a soft drink bottle and a child drinks it and dies, then clearly they're going to be potentially prosecuted of the gross negligence manslaughter. But if the child ignores it, that child's fine. There are no consequences. But clearly in that situation, the father has done exactly the same activity and it's the outcome that's absolutely everything. And that's obviously the case where you say, for example, in gross negligence manslaughter, if the patient is stronger or maybe younger, and they survive, then there were no criminal consequences. These prosecutions of Ian Paterson and Simon Bramhall, as far as I am aware, represent the first time that this kind of non-fatal harm has been the subject of criminal prosecution.

06:55 Professor Farrell:
Well, you've mentioned these two cases. Would you like to provide us with some background about Patterson and Bramhall and the circumstances which led to the prosecution?

07:05 Dr Mullock:
So the more serious of the two cases is clearly Ian Patterson, and probably many people have heard about this because it was all over the news around the time, with comparisons drawn between Patterson and Harold Shipman, and he was found guilty of non-fatal offences Section 20 in I think 3 counts, and 17 counts of Section 18 of the Offences Against Person Act. Obviously, those offences are GBH [and] wounding and the more serious offence under section 18 is GBH - wounding with intent. And essentially what he did is, he told many patients who thought they might have breast cancer; he assessed them, and he told them they did have breast cancer, when in fact they did not. And he went on to perform unnecessary interventions on those, mostly female patients, and in other cases he performed a discredited procedure called a partial mastectomy. Which is a contradiction in terms really, because

mastectomy means total removal of the breast tissue and he had this kind of cleavage saving mastectomy that he thought was a good idea. But it's been entirely discredited within that area of medicine, and he was ultimately prosecuted after many, many patients within his NHS practice and his private practice complained about him and he was ultimately prosecuted in terms of the victims harmed within his private practice. And I think that was because there was a clear narrative available for the prosecution in that he was selling these surgeries, and so in order to sell more he told people that they had cancer when they did not, and he was ultimately convicted, and he was given a 15-year sentence first. And then that was appealed by the Attorney general and now he's currently serving a 20-year sentence. In addition to the particular victims within the criminal prosecution, there are said to be many hundreds, potentially even more, and victims from over a decade of malpractice, both in the NHS and private practice.

09:33 Professor Farrell
I mean something that's raised by just generally in the Patterson case, but you would also argue in gross negligence manslaughter prosecutions arising from healthcare settings, that not only are you looking at the individual doctor in question, but they're situated within a system and within a professional culture. Now there were, as I understand it, certain evidence put forward that the practises of Patterson, and no doubt other doctors that may find themselves in these situations, where there was an awareness amongst its peers and also on a more systems wide basis or within the NHS trusts in which he was working and even in private practice, as to problems with his treatment of patients, so again, focusing on the doctor - appropriate in this case; he's been found guilty. But what would you say about these broader issues that are often raised by the medical profession as they're saying, well, the criminal law is not appropriate because there are systemic issues involved and what would you say to that?

10:33 Dr Mullock:
I think you're absolutely right. The culture and the context of that type of malpractice and abuse makes it possible for particularly senior consultants and senior surgeons to experience and enjoy, I think, a high level of autonomy. Certainly, in Patterson's case, there were many attempts over the years to address some of the problems so that the NHS hospital, but in particular where he was working, knew that there were very serious problems with his practice and there were some attempts to try and prevent him from doing certain things that were particularly problematic and he managed to kind of shut everybody down and it seems that, he's quite a forceful character and working within a hierarchical system where junior colleagues are afraid to speak up and makes it possible for bad apples like Patterson to get

away with malpractice for many, many years. And I mean, what's interesting actually about Simon Bramhall case; so he was a surgeon who used he was a liver transplant surgeon and during the course of liver transplants he branded patients new livers with an argon gas coagulator with his initials, SB. Now obviously he wasn't performing this surgery alone. There were colleagues surrounding him and they saw what he was doing and when this eventually came to light, because in a couple of the patients their transplants failed, so the transplant organ was removed and replaced with another organ, and at that point, because it was quite a recent transplant, because the liver regenerates, they saw visibly SB on these the livers of these patients. And at this point there was an investigation and some colleagues who'd worked with Bramhall said, “Yes, we did know that he did this.” And I think there was a senior nurse who said to him about it, “What are you doing?” And he just said, “Well, this is what I do.” And nobody reported him, and it wouldn't have come to light at all, but for the fact that these transplants failed so the evidence was clear.

12:54 Professor Farrell:
So once they realised that there was this branding of livers going on, what was the sequence of events in terms of holding this particular doctor to account and then how did it end up within the domain of the criminal law?

13:08 Dr Mullock:
Yeah, well, so that's a really good question. I'm not exactly sure, I mean it was. It was because Simon Bramhall just pleaded guilty, they didn't have to go through the process of finding evidence, and more evidence in this adversarial criminal court. He just held his hands up and admitted what he'd done and was given a suspended sentence. I think it was a fine and a record was put on his GMC registration, but he wasn't erased from the register. He was just reprimanded. And I understand that the GMC thought that, despite this abuse of patience and breach of trust, he was still deemed to be, a decent surgeon, as far as I'm aware.

13:58 Professor Farrell:
Based on what evidence because, I understand we often forget here that often when the criminal law intervenes, it takes precedence. But often the GMC, as the regulator of doctors, may want to review particular doctors’ conduct, normally following criminal proceedings. The Bawa-Garba case is a case in point around gross negligence manslaughter in a healthcare setting, but so I'm assuming there was a fitness to practise hearing? Would that be right?

14:30 Dr Mullock:
Yes, yes. No, there was. Absolutely. I mean in terms of fitness to practise, the branding of the livers was, by their medical professionals involved, deemed to be not at all harmful. So, it was only psychologically damaging to the patients I mean one of the patients was said to be very traumatised by the knowledge that this had happened, and she believed that had actually caused her liver to fail. Although the medical experts said that's not the case and the liver failed for different reasons and actually the branding of those livers didn't actually cause any harm to the patients. So therefore, in terms of his skill as a doctor and a surgeon he was, he was deemed to be safe and fit to practise, although obviously the horrendous breach of patient trust and so on.

15:31 Professor Farrell:
It's interesting because we're looking at, say, in the case of Bramhall in particular, a particular conduct problem, aren't we?

15:37 Dr Mullock:
Yes.

15:39 Professor Farrell:
Depending on how you view harm, and we may debate that, but it's setting that aside again. It's interesting how, for example, a regulator may view, conduct problem as opposed to a harm problem. We need to leave that for another podcast. But equally, does it not mean when you're looking at a conduct offence such as Bramhall for example, or conduct problem, that the criminal law is an appropriate mechanism for addressing that and particularly in the context of non-fatal harm being caused?

16:05 Dr Mullock:
Yeah, I do think it's an appropriate application of the criminal law. I mean, in both cases, obviously Simon Bramble didn't physically harm any patients in the view of the experts who looked at his behaviour, but he demonstrated a serious breach of trust. It was very arrogant, and there was no consent. Obviously, the law tells you that if you do something without a person's consent then that's potentially a criminal matter. Whereas obviously with Ian Paterson he did seriously, seriously harm many, many victims.

16:49 Professor Farrell:
Well, you've got conduct and harm. So you've got conduct with Bramhall and, debatable depending on with what perspective you may take, harm.

16:58 Dr Mullock:
Well, I mean I suppose with Bramhall the fact that one of the patients have been very emotionally affected by that and that might amount to some of some psychiatric injury. There is harm, potentially. But certainly with Patterson you saw both aspects of, an absolute breach of patient trust and very serious physical harm. And potentially it seems very likely that some of the patients that Ian Patterson didn't treat appropriately, for example, by giving them a partial mastectomy rather than a full mastectomy, then went on to have a recurrence of cancer that otherwise they might have avoided it. So I think it's very likely that some patients have or indeed will die because of his malpractice.

17:53 Professor Farrell:
So in terms of the current research you're doing, where do you end up in terms of the role of the criminal law in relation to non-fatal surgical harm? Is there a place for it? Do we need to amend? What is your proposed way forward?

18:08 Dr Mullock:
So I think there is definitely a place for the criminal law. I think there are lots of challenges. So in the paper that I sent you, which I'm hoping will be published in Medical Law International later this year, in this paper I look at the issue of consent and the way that that was that dealt with by the court, particularly in Patterson, and also the concept of reasonable surgery, because I'm sure students will know that consent to non-fatal harm is only available in certain contexts, and one of those contexts is reasonable surgery. So I look at what constitutes reasonable surgery? Clearly, we know from the booming cosmetic surgery industry where nontherapeutic cosmetic surgery is absolutely acceptable, that surgery doesn't have to be therapeutic in a clinical or medical sense, provided, it has benefits that people want, and provided that doctors are prepared to supply it. So I look at those issues around consent and the criminal requirements for consent, and also the civil requirements for consent and the difference. And one of the things I argue is that the threshold for lawful consent in the criminal law is actually too low and it's too deferential to the medical profession. And I also look at the, I mean there's lots of gaps in the law and there's limited authority about what reasonable surgery or even proper medical treatment is, because I think the single answer that you come to, and I did some work on this a few years ago with an edited book with Professor Sarah Fogg, the answer that you always come to when you're trying to look at, well, what does proper medical treatment mean? And what is proper is it's what the doctors believe is proper. So it doesn't really matter.

20:15 Professor Farrell:
Doctor knows best.

00:20:16 Dr Mullock:
Yes, but it doesn't matter if it's harmful for the patient or the patient thinks that's not what they consented to and that's not what they understood was going to happen. What matters is well, what does the medical profession think? Sort of Bolam-isation of these issues at almost every level.

20:33 Professor Farrell:
Also, we've only really got doctors doesn't know best around information disclosure, haven't we, but for diagnosis and treatment, you could argue doctor knows best in terms of the Bolam/Bolitho standard, for example, and that also feeds in. Then I suppose you could argue to the intervention of the criminal law. But wouldn't you argue though, or you look at the both the civil and the criminal aspects around consent and you're saying it's a low threshold? Some of the broader debates in the criminal law is around harm that's caused, and consent issues is seen as problematic anyway because of the possibility of the accused, for example, raising a range of defences around consent and that we come from a civil law perspective, which is much more about empowering the perceived vulnerable person in the context of consent. So did you find it interesting comparing the civil and the criminal law realm around consent, particularly in healthcare settings?

21:38 Dr Mullock:
Yeah, I touched on that, but what I found actually probably more useful is looking at consent within the criminal law in other offences and how things have moved towards a more victim centred approach. So for example, with sexual offences and also with cases like HIV, so you know the classic kind of Dica case where a woman consented to have sex with the defendant but obviously didn't consent to being infected with a serious disease and there were the previous authority going back years and years and I can't remember the name of the case, is that if you consent to that? Tough luck. You get whatever you get, whereas obviously that's changed now. And I think there's much more respect for the victim and also through the cases involving prosecutions for herpes as well. So I look at those sorts of examples. Harm, on the face of it, is consented to. But in actual fact, the victim, didn't realise what they were consenting to. And I draw an analogy between that kind of consensual sex which leads to serious harm and surgery that on the face of it is consensual, but also leads to serious harm

23:06 Professor Farrell:
In terms of the decision to prosecute and this may not be something you deal with in too much detail, but for example, do you think when the decision is made to prosecute a doctor, we're looking at comparing Patterson and Bramhall in these situations around non-fatal surgical harm, do you think there's a more of an interest in the conduct side of things or the conduct and/or harm, because they are two different cases. Did you notice any differences in prosecutorial approach or preparedness to prosecute, perhaps based on conduct as opposed to a harm and conduct case?

23:41 Dr Mullock:
There are only these two cases that have been prosecuted. So it's difficult to draw any firm observations or conclusions about the difference in prosecutorial attitudes to conduct compared to harm. I think conduct is probably crucial in one sense though, because with Ian Patterson, he was harming patients for well over a decade and it was only when this kind of volume of victims and the weight of evidence became really just impossible to ignore that he was investigated and prosecuted. I mean, with Simon Bramhall there were only, I think two clear examples of the liver branding, but there's the very likely observation that he did this to many more patients, but we'll never know because their livers are tucked safely inside them, and would be healing anyway, so the fact that he was prosecuted with a much smaller body of evidence and no physical harm suggests that conduct is really a compelling reason. And that kind of example of completely breaching patient trust and doing something to patients without their consent is thought of as very serious. With Patterson it was much more difficult I think for the police and CPS to gather the evidence because on the face of it, all these patients did consent to the surgery, and he did the surgery that he told them he would do. I think it must have been incredibly difficult for them given that we know that reasonable surgery is acceptable - it's an exception to the usual criminal law principles and on the face of it he was, you know, a hard-working surgeon and doing what surgeons do, so I think the context makes it so difficult for these cases to be investigated.

25:57 Professor Farrell:
So we've looked at the investigation thing. So where should we go with these sorts of prosecutions in the future? What are your conclusions as a result of your examination of this issue?

26:08 Dr Mullock:
So I think my conclusion is that we need to rethink the basis of real or valid consent in the criminal law, to give to have a more patient centred approach that's more respectable of

patients and demands more of the medical profession. And we also need to understand what reasonable surgery is so that when you have a surgeon for example, who is not providing informed consent but does nevertheless tell the patient just about enough to satisfy the Chatterton v Gerson standard of information in broad terms, but then goes on to seriously harm a patient by either botching the surgery or performing inappropriate surgery, then I think we need to look at the consent interaction and we need to look at the concept of reasonable surgery and if consent is found wanting and the surgery is not reasonable, and causes this serious harm to the patient, then I think you know the criminal law is entirely appropriate and in fact it could provide a useful deterrent to bad apple surgeons who might be more careful before they continue practising in the way that that that they do.

27:35 Professor Farrell:
Just as a final point, when we're looking around consent and you talked about context being important and obviously on evidentiary basis that's important as well, particularly the likes of Patterson, but is there not a gender dimension? Do we need to take account of that? Are there other dimensions, such as the situation of particular patients, for example, socioeconomic status, social determinants of health? Obviously in Patterson it was very obvious that we're looking at female women patients here. But in terms of rogue surgeons or bad apple doctors, however you want to describe it, what are the other dimensions that we should take into account about the specifics of the patient? I know we talk about reasonableness so that may be problematic, but we're looking at a particular context here, aren't we?

28:31 Dr Mullock:
Yes, and I'm really glad you reminded me about the gendered issue in particular. I'll come back to that in a second, but I think there is definitely a gendered issue and a socio-economic issue as well. Some patients are more vulnerable than others in the context of these interactions. What I did find as well in terms of, obviously with Patterson, he was a breast surgeon. So you've inevitably going to get a vast majority of female patients and in other areas of practise which seemed to be particularly dangerous, such as gynaecology; you're inevitably going to get only female patients. Cosmetic surgery is another interesting one that seems to be particularly hazardous. And again, women are more likely to be consumers of that type of private medical intervention. And although I wasn't looking at the gendered issues within my research on bad apple surgeons, it still became apparent that women are far, far more likely to be victims of bad apple surgeons, and not only because gynaecology is dangerous, or cosmetic surgery is dangerous, but there's something else going on and in all the cases that I looked at. So I looked at a range of cases that had involved GMC investigations. All the bad

apple surgeons were male, which obviously surgery is a male dominated specialism, but there were no female surgeons that I in my in my research that had been accused of harming patients. And almost all the victims were female, even outside the obvious areas of gynaecology where you're not going to obviously get male surgeons. And so I started to wonder whether this is another example of male violence towards women and particularly within gynaecology there's been a lot of bad apple surgeons in gynaecology and historically there were a couple of really serious cases. Rodney Ledward and the gynaecologist Neale, I forget his first name [Richard Neale]. But then recently, we've got some, probably won't name names just in case but there's at least three very, very serious examples of gynaecologists harming many, many women, two of which have been the subject of a big group action in negligence and I just wonder, I have no idea and I don't have the skills to start to look into what exactly is going on. Why is it that gynaecology seems to be such a very dangerous area of medicine? And why is it that bad apple surgeons seem to find themselves becoming gynaecologists and then going on to harm so many women? And then more broadly, there are other examples. The doctor called Steven Walker was eventually prosecuted for gross negligence manslaughter after the death of a female patient back in the 90s, but he'd harmed and killed many other female patients, despite the fact that, his [specialty] wasn't a gendered area of medicine. And if we look at the worst bad apple doctor ever, Dr Harold Shipman, all 15 of the victims that he was ultimately found guilty of murdering were female, even though he was a GP and presumably had an equal number of male patients. So I think what we need to do is, if possible, somebody with the expertise needs research what this character dimension here is with these bad apple surgeons who go into areas of medicine where women are their patients and then subsequently potentially their victims.

32:33 Professor Farrell:
No, I think that's a very interesting point and as you say, quite rightly, ripe for further research in the area. And again, we only have to look at, for example, the vaginal mesh cases as well breast implant cases. And we're looking at broader problems around medical device regulation as well. But also, decisions in the context of the doctor patient relationship to proceed on that basis. We also have our data showing that there are certain high risk medical specialties for clinical negligence claims as well and they tend to fall in the surgical specialties. And that may be because of the type of treatment or surgery they're undertaking, but it would certainly be worthwhile to really drill down into any gendered issues. That and other inequality issues that may be at stake. And I suppose it feeds into my final question, which is, the rightful domain of the criminal law - you've clearly argued it. There is a place for it in in cases of non-fatal surgical harm, but there is a broader range of issues here that the criminal law is

highlighting around professional culture, around perhaps gendered harms that may be caused, the role of the regulator? So is criminal law really leading the way? Or do we need to step back, do more research, but take a broader approach to the nature of doctor patient relations that are bringing this about?

34:06 Dr Mullock:
Yeah, I mean the criminal law, although I do think it certainly does have a role in these very serious cases, it's a blunt tool. And what we really need to do is look behind these cases and see why this is happening and why there is a tendency for the doctors who are bad apples to get away with it for so long and obviously there's potentially a regulatory deficit there in the way that the medical profession is still fundamentally a self-regulating profession with high levels of professional autonomy particularly with senior doctors. I think it's probably not the case in many contexts and certainly with junior doctors, but there's a problem with this hierarchical systems and cultures that have been developed.

35:08 Professor Farrell:
Well, thank you very much. Very interesting discussion of your research in the broader area of the role of the criminal law in health and medicine.

35:17 Dr Mullock:
Thank you.

35:19 Professor Farrell:
Thank you very much. Doctor Alex Mullock, Co-director of the Centre for Social Ethics and Policy at the University of Manchester. You've been listening to our podcast on Current Issues in Health Law and Bioethics. Thank you.

35:35
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35:54
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Transcribed by Leyla Noury